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POPULI

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Cover: **Richard Mock**/Men are more likely to infect women with HIV than vice versa.

READEX
FICHE

What's in a Neem?

The neem tree, long considered a wonder plant in its native South Asia, is attracting scientific interest in the West. For centuries, the tree has been used to cure aches and pains and to treat chicken pox. Scientists are adding to the list of its useful qualities. According to a report by the US National Research Council, the neem tolerates drought and repels insects. Reforesting tropical areas with the neem could reduce soil erosion and provide a wide variety of marketable products for poverty-stricken people. Neem produces substances that can be used in dental hygiene and to treat ulcers and inflammation. Some compounds even "show early promise as the long-sought oral birth control pill for men," according to the report.

Medical Market Economy

Health officials from Kyrgystan, Turkmenistan, and Uzbekistan, all members of the Commonwealth of Independent States (CIS), arrived in Washington, D.C. on 1 December. Their fact-finding tour of the United States reproductive health service delivery system was sponsored by the US Agency for International Development (USAID). The two-week tour took health ministry officials from the three countries to public and private reproductive health centres, pharmaceutical manufacturers, and the US Food and Drug Administration, according to a statement from the Futures Group, a USAID sub-contractor. Abortion remains the most widely used method of fertility regulation, and the IUD virtually the only contraceptive, in the three CIS countries, according to the statement. The US tour was to instruct the visiting officials in "how a medical market economy functions and provide guidelines for pharmacy privatization," the statement reads.

Fatty Acids and AIDS

Treatment of AIDS patients in Tanzania with essential fatty acids (EFAs) appears to have beneficial results, according to a recent report in *Archive AIDS Research* based on a small-scale study at the Muhimbili Medical Centre. Twelve patients diagnosed with AIDS were selected for the study, and were given capsules containing EFAs derived from a mixture of evening primrose and fish oils. After 12 weeks, the patients reportedly had gained weight and seen improvements in their condition. They suffered less from fatigue, diarrhoea, and skin rashes. None of the patients reported any adverse effects of this treatment. A larger placebo-controlled study of EFAs, in which some patients receive EFAs and others receive dummy treatment, is now under way at the University of Dar es Salaam, Peter Sofroniou reports in *WorldAIDS*. Much larger trials may follow in Zambia and Uganda. These indications of success follow earlier reports of success with holistic and alternative treatments including nutritional therapy, yoga, and meditation. Researchers at the Univesity of California at Berkeley, USA say nutrition plays a part in delaying the onset of full-blown AIDS in HIV-positive people, although they warn they are not sure why this is so. A hospital in San Francisco, USA specializing in alternative treatment reports the condition of patients with symptoms of full-blown AIDS has stabilized and even improved over periods as long as seven years. Hospital officials warn, however, that they have not been able to identify a common element in the treatment of patients that might be responsible for the success.

Yes, But...

Organizers of the Tenth International AIDS Conference, scheduled for Yokohama, Japan in 1994, say that no one will be refused entry to the conference because they are HIV-positive or have AIDS. However, it may be "very difficult" to grant visas to participants who state on their applications that they are commercial sex workers or drug users, health ministry official Shimpei Ozaki is quoted as saying in *WorldAIDS*.

Quinacrine Critics

Critics are blasting a new method for non-surgical sterilization of women. The irreversible method involves placing a "pellet" of quinacrine, a chemical irritant, in the uterus. The pellet, which costs pennies per application, is raising fears among health experts who question its safety and its potential for social abuse. The method, developed by a gynaecologist in Chile in the 1970s, has not yet been approved by any major drug regulatory agency. After considering the toxicology of quinacrine, the World Health Organization (WHO) "recommended in 1991 that further research on the intrauterine administration of quinacrine for female sterilization was not justifiable," says Nicholas Dodd of UNFPA's Technical and Evaluation Division. Moreover, given that little is known about the drug's potential to cause mutation or cancer, WHO "recommended that additional animal studies should be developed before considering" placing the pellets in a woman's uterus. Since UNFPA only recommends the use of contraceptives approved by WHO, Dodd adds, "UNFPA is not currently supporting any trial or clinical use of quinacrine as a method of female sterilization." Nevertheless, more than 80,000 women in the developing world have been sterilized with the pellet, the *Philadelphia Inquirer* reports. WHO plans to hold further consultations on new technologies for female sterilization in early 1994, Dodd says.

Europe's Plunge

Europe's fertility rate is at its lowest since records began 36 years ago,

according to a European Community (EC) report released on 1 December. Women in the EC have an average 1.48 children, compared to 1.82 in 1980. Spain has the lowest rate: 1.23 children per woman. In Italy, where the rate is ! 26, the government is looking into using EC grants as an incentive for women to have more babies, according to the *Daily Telegraph* of London.

Irish AIDS Ads

AIDS prevention advertisements will appear on Irish television after the Labour Party government won a "fierce" battle with conservatives who attempted to block the ads, *Family Planning World* reports. Health Minister Brenda Howlin seized upon the recent liberalization of the country's condom laws to produce government-sponsored AIDS prevention ads for Irish TV. Conservatives attacked the ads as promoting sexual promiscuity. The government countered that the ads were aimed at those who were already sexually active. The government recently approved the sale of condoms through vending machines by removing them from the official list of contraceptive devices and thus freeing them from restrictions.

ICPD Update

The latest on the lead-up to the International Conference on Population and Development, 5-13 September 1994, Cairo, Egypt.

ICPD Goes Electric

ICPD 94, the official Conference newsletter, and other information from the ICPD Secretariat is now available on several electronic communications networks, including Internet and the TogetherNet gopher on Internet (international), EcoNet (US), Web (Canada), GreenNet (UK), Pegasus (Australia), and Alternex (Brazil). For more information, see the November/December 1993 issue of the newsletter or contact the ICPD Secretariat by E-mail (ryanw@unfpa.org).

Upcoming Events

- Through mid-December, UN Headquarters, New York: Forty-eighth regular session of the UN General Assembly; discussion of ICPD on the agenda.
- 1-3 December, Lima, Peru: Andean Meeting on Population and Development.
- 2-3 December, Vienna, Austria: Round-table meeting on Population and Communication.
- 2-3 December, Port of Spain, Trinidad and Tobago: Caribbean Meeting of Experts for a Plan of Action on Population and Development in Preparation for ICPD 1994.
- 26-28 January, Tokyo, Japan: Meeting of Eminent Persons in Population and Development.
- 14-16 February, Washington, D.C., USA: Round-table meeting on Population and Food in the Early 21st Century: Meeting Future Food Needs of an Increasing World Population.
- 4-22 April, UN Headquarters, New York: Third meeting of the Preparatory Committee for the International Conference on Population and Development 1994.
- 3-4 September, Cairo, Egypt: Pre-Conference consultations.

World AIDS Day:

Time to act

World AIDS Day fell on 1 December and emphasized that it that it is now "Time To Act," according to the World Health Organization (WHO), the Day's official sponsor.

More than 14 million women, men, and children are now estimated to have been infected with HIV, the human immunodeficiency virus. More than 5000 new infections are thought to occur every day. "Without urgent action, the number could reach 40 million by the end of the century," according to an official WHO statement.

As of 30 June, there had been more than 2.5 million cumulative AIDS cases since WHO began keeping track about a decade ago. Half of all officially reported AIDS cases are from developing countries. These countries are thought to account for as many as eight in ten cases, however.

In the developing world, two-thirds of all estimated AIDS cases are thought to have occurred in sub-Saharan Africa. HIV infection has been spreading rapidly in South and Southeast Asia, however, with over 1.5 million cumulative HIV infections as of 30 June.

Jorgen Schytte

Needed: More education about AIDS.

At least half of all HIV infections worldwide have occurred in youth 15-24 years old, according to WHO's Global Programme on AIDS (GPA). One-fifth of the world's population—more than 1 billion people—is estimated to fall into this age group.

WHO is calling for more sex education. The agency's studies have revealed no evidence that sex education in schools leads to increased sexual activity among young people. On the contrary, in 10 out of 35 studies examined, sex education increased the adoption of safer sexual practices in youth who were already sexually active.

The most recent study reviewed by WHO followed a sample of boys aged 15-19 in the United States in 1992. It found the majority of them had received formal instruction on AIDS, contraception, and resisting social pressure for sexual intercourse. The results: they had sexual intercourse less frequently and with fewer partners, and were more diligent about using condoms.

What about adults?

The 1992 Demographic and Health Survey (DHS) of Zambia found nine of 10 women knew that AIDS can be transmitted sexually. Sixty per cent had heard about AIDS from a friend or relative, 39 per cent had heard about it on the radio, and 35 per cent had been told about it by a health worker. Yet, nearly 30 per cent said—incorrectly—that AIDS can be transmitted by sharing clothes or eating utensils with someone who has AIDS. Sixty-one per cent said—again, incorrectly—that you can get AIDS from mosquito, flea, or bedbug bites.

Twenty-eight per cent said they did not believe the disease can be prevented. Among the 63 per cent who knew the disease can be prevented, 93 per cent said monogamy was a means of prevention. Only 8 per cent mentioned condom use, however.

In Tanzania, the 1991/92 DHS found more than half of men believed—incorrectly—that condoms can be used more than once. Nearly one-fourth said they believed they could get AIDS from a condom. In the four weeks before the survey, 30 per cent of men had multiple sexual partners, but only 9 per cent reported using a condom.

Condom information programmes may act to the disadvantage of women. Mary Owor, manager of a school health project in Uganda, told Gemini News Service that in 83 per cent of schools studied, students said they felt AIDS was spread by women. This might be,

she said, because a condom is a protective device worn by men, who would think the advice to use one was being given to protect themselves against infection.

In fact, as author Gena Corea points out in *The Invisible Epidemic: The Story of Women and AIDS*, research shows that a man is ten times more likely to transmit HIV to a woman than the other way around. WHO data show infection rates among women outracing rates among men.

As for the prospects of new contraceptive methods that can be used to prevent infection, Mahmoud Fathalla, biomedical and reproductive health adviser to the Rockefeller Foundation noted in October's POPULI that "researchers have yet to develop a contraceptive method that women can control and use to protect themselves against not only unwanted pregnancies, but sexually transmitted diseases...HIV, and AIDS."

No condom, no sex

AIDS monitors at the US Bureau of the Census and elsewhere are calling India a "silent volcano." According to one census bureau report: "Within a few years, India may be facing the same problems as seen in some African countries."

An Indian government survey has found the rate of HIV infection to have risen from three cases of infection per 1000 people in 1986 to 11 per 1000 in 1992.

"I fear that if it is not controlled properly, AIDS will explode in the form of an epidemic by the turn of the century," says Dr. P.R. Dasgupta, project director at India's National AIDS Control Organization.

Key elements of government strategy include improving blood safety standards, controlling sexually transmitted diseases (STDs), and promoting public awareness. Students are being enlisted to educate people under the 1991 programme "Universities Talk AIDS."

Nationwide surveys show commercial sex workers are particularly vulnerable to HIV infection. The city of Bombay, for example, has an estimated 100,000 commercial sex workers; a recent survey found 42 per cent of them to be HIV-positive, meaning that they carry HIV antibodies, the presence of which is taken to indicate HIV infection.

Some NGOs have begun to educate sex workers about the dangers of infection and to observe the so-called "no condom, no sex" policy.

Doctor and social worker I.S. Gilda has set about trying to bring the message to Bombay's red light district. Under his supervision, sex workers educate each other about AIDS and distribute condoms.

It is a three-tier system. At the bottom is a *saheli* who is in charge of 20 sex workers. Above her is a *tai*, in charge of ten *sahelis*. At the top is the *bai*, who presides over an entire district.

A *saheli* is paid 100 rupees (about US$3.00) per month for an hour's work each day among her workers. The *tais* get 600 rupees for part-time and 1000 rupees for full-time work.

The *bai*, being a woman of stature and influence, avoids monetary compensation. Says Gilda: "She is often won over by a piece of logic, [something like] 'Don't you want your girls to keep good health, especially considering how much you have spent on them?'"

The results, Gilda claims, have been fairly good. The slogan "no condom, no sex" is fast catching on with sex workers, and other NGOs are trying the same approach in red light districts across the country.

There's just one problem. "In this business, the client is the king," says social worker P. P. Patkar. "Prevention is usually in his hands, and he generally refuses to wear a condom because he believes the pleasure isn't the same."

The task now is to educate frequent visitors to brothels. With this in mind, some NGOs are looking into educating specific groups such as police officers, taxi drivers, and pimps.

-A.J. Singh/Gemini News Service

No justice, no peace

Discrimination is "a societal lesion which, if not treated, facilitates and promotes the spread of HIV." This, according to Jonathan Mann, professor of health and human rights and director of the International AIDS Center at Harvard University in the USA.

Addressing a conference of health experts in Paris on 6 December, Mann blasted discrimination against women and the poor.

"AIDS is more about people, their interactions, how they are treated by society, than about a virus," he said. And the evidence shows that "male dominated societies are a threat to public health."

He drew from studies in Africa, Europe, and the United States to show that "discrimination creates an environment of increased risk for women, linked directly with their unequal role, rights, and status. Women cannot say 'no' to unwanted or unprotected [sex] unless they have the economic and social power to mean 'no.'...Therefore, reform of laws governing property distribution and divorce may be much more important in helping to prevent HIV infection than increasing the distribution of brochures or condoms."

He also lamented the "enormous inequity in the availability of resources to prevent and control HIV/AIDS." Of "the US$1.5 billion spent worldwide on prevention in 1991, only 6 per cent was for the developing world, which has nearly 90 per cent of all HIV infections. Thus, in 1991, about US$2.70 was spent per person in North America, compared with only 7 cents in sub-Saharan Africa and only 3 cents per person in Latin America."

Haves, have-nots, and HIV

AIDS investigators have scrutinized our genes, our bodies, our cultures. What about our incomes?

A study in Kigali, the capital of Rwanda, found that women's risk of infection with HIV, the human immunodeficiency virus, increased the higher their male partner's income. "In fact," according to the study's authors, "the education and income of the male partner were more strongly related to infection in the woman than these same variables in the woman."

Why? Because male partners with more money to spend tended to spend it on alcohol and commercial sex. And because they wielded power over their generally less-educated, non-salary-earning, dependent female partners.

Researchers tracked three "demographic predictors" of HIV infection: marital status, male partner's income, and the length of the relationship or union.

Fifty-three per cent of women in high-income common law unions for fewer than seven years were infected, as compared to only 16 per cent of "legal wives in long-term, low-income partnerships," according to the authors. Common law unions are similar to legal marriages except that they do not require payment of a dowry.

Only 13 per cent of the women interviewed had salaried jobs. Fifty-nine per cent said their occupation was housework; 19 per cent, farming family-owned land; 8 per cent, entrepreneurship.

Women whose partners were farmers or soldiers were less likely to be infected than women whose partners were in the private sector or in the civil service. Farmers had low incomes, and most lived in the rural outskirts of town where HIV prevalence was lower. Women whose partners who travelled for more than one week each month were not at significantly greater risk of infection than women whose partners stayed at home. These findings seem to fly in the face of most research in Central Africa, where the highest rates of HIV infection are found in urban centres, along truck routes, and in areas recently under military occupation.

Thirty-four per cent of the women said they were in a monogamous relationship with a man. Twenty-six per cent said they were not sure whether their partner was monogamous. These two groups had the lowest infection rates. Twenty-seven per cent, or 388 women, said their relationship was non-monogamous; 378 of them said only the man had other partners. The prevalence of HIV infection was considerably higher in this group.

Women who knew that their steady partner visited prostitutes, had contracted a venereal disease (VD), or drank alcohol were more likely to be infected. Men who drank alcohol were more likely to have had a VD—22 per cent, as compared to nine per cent among men who didn't drink. Men with higher incomes were more likely to visit prostitutes and to have had a VD than their lower-income counterparts—21 per cent, compared to 15 per cent in both cases.

Eighty per cent of the women's primary partners drank alcohol; half were frequent drinkers, according to the women. Drinking habits among high- and low-income men were similar, but the risk added by drinking was greater among the haves: 43 per cent of wives of high-income frequent drinkers were infected, compared to 27 per cent of wives of low-income frequent drinkers. Among the wives of non-drinkers, the high-income rate was 22 per cent; the low-income rate, 19 per cent.

So there's a class angle, in addition to the gender angle. The authors commented: "Increased alcohol and drug use has been associated with high-risk sexual activity... in the United States [, too]. This may be due to sexual disinhibition when drinking, or to the fact that substance abuse and high-risk sex are common in the same social circles."

The study, by an international team headed by Susan Allen of the University of California at San Francisco, appeared in the *Journal of the American Medical Association* in September 1991. Its findings are of note to political activists and others who argue that AIDS attracts so much more attention than tuberculosis, malaria, or maternal mortality, in part because it is almost always the poor whose lives are claimed by these other causes.

-Abid Aslam

UNHCR/R. Del Percio

Checking identity papers in El Paso, USA.

Seeking sanctuary

One in every 130 of us—some 44 million people in all—have been forced to flee our homes by conflict or oppression, according to the office of the United Nations High Commissioner for Refugees (UNHCR). But as the ranks of the refugees swell, countries are closing their borders. The existing system of protecting refugees is threatened with collapse.

During 1992, an average of 10,000 people were displaced every day, according to UNHCR's first detailed global report, *The State of the World's Refugees: The Challenge of Protection.*

"The massive number of people on the move has weakened international solidarity and endangered the time-honoured tradition of granting asylum to those in genuine need of protection," according to the High Commissioner, Sadako Ogata.

According to the report, the number of people who have fled across borders rose from 2.5 million in 1970 to 18.2 million in 1993. The figure is thought to have risen to around 19.7 million following the recent coup attempt in Burundi, UNHCR spokesperson Sylvana Foa told journalists at the report's launching in November.

More than 24 million people are living as displaced persons within their own countries, largely because of civil wars.

Countries that have traditionally granted asylum to refugees are closing their doors, partly in acquiescence with racist and xenophobic sections of their own populations, the report states. "It is hard to find a country that has liberalized its asylum policy since the end of the cold war," Foa said. "Today, in many countries, it is almost impossible to get asylum when you are fleeing political or racial oppression."

Among industrialized countries, Germany has given shelter to the most refugees: 827,000 at the end of 1992, according to the report, which adds that the country is now tightening its aslyum laws amid a wave of attacks against foreigners. In the developing world, Iran was home to 4.1 million refugees from Afghanistan and Iraq at the end of 1992. Pakistan had 1.6 million Afghan refugees, and Malawi had one million refugees, most of them from Mozambique. The United States and Canada had taken in about half a million refugees each.

AIDS AND POPULATION:

Think Again

By Hugh O'Haire

It is time to dispel the notion that the human immunodeficiency virus (HIV)/AIDS (acquired immune deficiency syndrome) pandemic will significantly reduce and even reverse population growth, according to experts who participated in a recent round-table conference in Berlin.

Despite persistent rumours to the contrary, HIV/AIDS infection rates are unlikely to make a significant dent in any given country's population growth rates, the experts concluded, citing the latest evidence from the most-affected African countries and cities. The evidence suggests that, in these places, the HIV/AIDS infection rate reaches a plateau at 25-30 per cent of the local population. This is far short of the infection rates that would halt, let alone reverse, population growth.

The experts gathered in Berlin for a 29 September-1 October round-table on "Population Policies and Programmes: The Impact of HIV/AIDS" organized in preparation for the 1994 International Conference on Population and Development. Their general conclusions suggest an emerging consensus on the pandemic's demographic significance; the experts themselves have been at odds (see box, next page).

The main impact of AIDS, the experts said, will be to lower life expectancy through increased infant and young adult mortality; impede economic development as it kills people in their productive years; and force dramatic social change by depriving societies of many of their young and middle-aged adults, particularly women, while making orphans of their children.

Hugh O'Haire is a contributing editor of POPULI.

In the absence of a cure or vaccine, the best way of preventing the spread of the disease is to try to change sexual behaviour by disseminating information about HIV/AIDS and to encourage the use of condoms. This makes integrated family planning and HIV/AIDS programmes the front line of defence, according to the experts, who included academics and representatives of national and international agencies and non-governmental organizations.

However, the experts added that some sub-national regions and a small number of large cities could experience markedly reduced population growth for short periods. But these downswings would be quickly cancelled by immigration from surrounding areas.

The experts warned that their findings were based in part on anecdotal data, and that further research and analysis of more comprehensive data is needed. To date, information on HIV/AIDS infection has been collected from specific groups such as commercial sex workers, homosexuals, and intra-venous drug users, or from cities and other small areas. Data have yet to be collected and analyzed on a national level.

Nevertheless, in their view, 10-15 per cent of the populations of the most seriously affected countries are HIV-positive, meaning that they carry HIV antibodies, the presence of which indicates HIV infection. By contrast, in order for AIDS to reduce a country's population growth to zero, almost half of its inhabitants would have to be infected. Most participants at the Berlin meeting said they felt that was unlikely.

The case of Uganda, one of the first countries to reach high levels of infection and one of the most-studied countries for AIDS, was used as an example of how the disease progresses. The infection rate in Kampala, the capital, would have to double from its current 25-30 per cent for the city to experience negative population growth. The country as a whole would have to reach these levels for it to experience negative population growth. But infection rates for the rest of the country are much lower than those in Kampala.

The view that AIDS will take care of the population problem is wrong.

Uganda will experience higher mortality rates and consequently a statistical lowering of the average life span of Ugandans, but the country's high fertility will fuel an expanding population despite AIDS, according to United Nations projections.

According to the World Health Organization (WHO), there are 14 million people at present known to be infected with HIV worldwide. (Many experts say there are a considerable number of unreported HIV cases, however.) The number of people infected with HIV is projected to rise to 30-40 million by the end of the decade. Sub-Saharan Africa is being particularly hard hit by the disease: it is home to 8 million of the 14 million people already

infected. The infection is now spreading with alarming speed in South and Southeast Asia.

The experts gathered in Berlin made clear that the HIV/AIDS pandemic and its consequences—widespread death and sickness—will continue to affect countries, communities, and individuals for many years to come. No county or population will be immune. It was noted that media misinterpretation of AIDS's demographic impact has led some to argue that the disease will greatly lower or even halt population growth—and thus eliminate the need for family planning programmes—in many developing countries, especially in Africa.

"The view held by some people that 'AIDS will take care of the population problem' is completely erroneous," the experts stated in their written recommendations to the 1994 population conference. "Existing information indicates that AIDS will not lead to reduction in the size of populations even in countries with a high prevalence of HIV. In such countries, the population doubling time will be increased by only a few years as a result of AIDS mortality and decreased fertility."

The real impact of AIDS will be on the structure of societies since it kills people in their most productive time of life, between the ages of 20 and 40, according to UNFPA Executive Director Nafis Sadik.

"While projected mortality will not significantly affect already rapid population growth, the loss of productive workers, burdens on health systems, growing numbers of orphans, and disruption of families will threaten social, economic, and political stability in many parts of the developing world," she said. "This in turn will threaten the development plans of many Third World countries and could have global economic consequences."

The experts pointed out that AIDS is increasingly killing women. According to WHO, nearly half of all newly infected adults are women. More than one million women will be infected in 1993 and by the year 2000, more than 13 million

Differing Views

Much demographic HIV/AIDS research has been conducted using modelling and analysis techniques based on AIDS data from Africa. It has produced two schools of thought: those who say that AIDS might have a negative effect on population growth in countries with high rates of infection; and those who say that it will have little overall effect.

Professor R. M. Anderson of the University of London has been prominent in the first school. Last year, he told a conference in Nairobi, Kenya that AIDS could lead to zero or negative population growth in some countries within 20 years.

John Bongaarts, vice-president and research director at the New York-based Population Council, has been prominent among the second school. His calculations show HIV prevalence reaching plateaus at levels where AIDS would slew population growth in some countries, but would not lead to negative population growth in any of them.

Papers and articles discussed during the Berlin round-table meeting on AIDS and population give a sense of the differing views on the subject:

"Current data reveal substantial variations in the degree of spread between and in countries, but new analyses support earlier predictions that in the worst-afflicted areas AIDS is likely to change population growth rates from positive to negative values in a few decades." —R. M. Anderson et al, "The spread of HIV-1 in Africa: sexual contact patterns and the predicted demographic impact of AIDS," *Nature*, Vol. 352, 15 August 1991.

"[W]e can conclude that population growth rates are unlikely to turn negative in Central Africa. More likely, the population growth rates in Central and East Africa will not drop below half their current values." —John Bongaarts, "A Model of the Spread of HIV Infection and the Demographic Impact of AIDS," *Statistics in Medicine*, Vol. 8, 1990.

"Researchers agree that [in Africa] negative population growth will not occur unless adult HIV prevalence reaches 30 to 50 per cent. The big uncertainty lies in projecting future levels of HIV infection....in populations with AIDS epidemics, the level of adult seroprevalence will eventually level off well below 100 per cent, even if no behaviour change takes place. These plateaus occur as certain high-risk groups become saturated. In prostitute groups, for example, infection levels may quickly rise to about 80 per cent. At that level, the prevalence may stabilize as infected people drop out of the group or die and new, uninfected people join the group." —African Population Advisory Committee, *The Impact of HIV/AIDS on Population Growth in Africa*, 1993.

"Uganda is projected to be severely impacted by AIDS. Owing to the early onset of the epidemic, by 1990 the population size was already 191,000 less than would have been expected (or 1.1 per cent). The percentage differential is projected to widen rapidly with time. The population loss due to AIDS is expected to reach 726,000 (or 3.4 percent) by 1995, 1.5 million (or 6.2 per cent) for 2000, and 2.5 million (or 8.4 per cent) in 2005....The increased numbers of deaths will not prevent the population from doubling over the 25-year time-frame [1980-2005]. The pace of fertility will affect future population growth in Uganda far more than the impact of AIDS or any other demographic parameter. Nevertheless,...the average Ugandan at the turn of the century will live 11 years less that he would have without AIDS." —Population Division, Department of Economic and Social Information and Policy Analysis, United Nations, *Demographic Impact of AIDS in 15 African Countries*, 1993.

– H. O'H.

women will have been infected while about four million will have died from the disease.

Unprotected sex involving men and women remains the chief cause of the spread of AIDS, according to WHO studies. "In industrialized countries, where homosexual contact and needle-sharing used to account for nearly all infections, there is an ominous rise in heterosexual transmission," said Michael Merson, executive director of WHO's Global Programme on AIDS. "The result is a growing AIDS burden in women. Last year in the USA, for example, AIDS cases in women were almost 10 per cent higher than the year before. AIDS is now the leading cause of death among women of childbearing age in nine major US cities."

In developing countries, heterosexual transmission has been the disease's main vehicle from the beginning. But rates of infection among women are now outstripping those among men. In sub-Saharan Africa, women becoming infected with HIV outnumber men six-to-five, according to WHO.

"As infections in women rise, so do infections in the infants born to them. To date, these total about one million, of whom more than half a million have already developed AIDS. On average, worldwide, about one-third of babies born to HIV-infected mothers are themselves infected," Dr. Merson said.

He added that the socio-economic inequalities and dependence imposed on women and their sexual subordination to men are two major reasons for their rising infection rates.

"Because of the role that women are made to play in families as care givers and providers for younger and older relatives, the effects of the rise of infection among women has had a devastating effect on families," Dr. Sadik said.

What's needed

The experts recommended:

- that accurate information be distributed to policy makers to counter the erroneous belief that AIDS will reduce the size of populations in countries with a high HIV prevalence;
- that AIDS prevention efforts involve not just health but other social and economic sectors;
- that societies encourage frank discussion of sex with the aim of reducing risky sexual behaviour;
- that firm political commitment be given to women's empowerment and especially to enhancing women's ability to make reproductive choices;
- that AIDS prevention activities and family planning programmes be made an integral part of national AIDS control strategies;
- that family planning providers and other primary health care workers be trained in AIDS prevention and management of sexual transmitted diseases (STDs);
- that AIDS and STD prevention programmes and family planning programmes reinforce each other's public awareness campaigns, to promote the goal of sexual and reproductive heath;
- that family planning programmes actively promote condom use for disease prevention;
- that young people be informed on responsible parenthood and disease prevention before they become sexually active, and that family planning services and counselling be provided once they become sexually active;
- that national governments and international agencies put more effort into demographic and epidemiologic research and support research on ways of improving programme effectiveness and technology development; and
- that national governments and international agencies commit additional resources to family planning and HIV/AIDS prevention programmes.

Ted Cunningham

Front line of defence: Promoting condom use.

According to one WHO study, it would take $2.5 billion annually to fund efforts that could prevent almost one-half of projected new HIV infections by the year 2000 in developing countries. This figure would include the provision of condoms, the promotion of their use, and treatment for STDs. The feeling at the Berlin meeting was that, given the worldwide recession, there is little hope of raising the money.

AN AIDS VACCINE?

Trials and Tribulations

by Neil McKenna

Large-scale trials of possible AIDS vaccines are set to begin in the next two years in a number of developing countries. These trials move the quest for a safe and effective vaccine against AIDS (acquired immune deficiency syndrome) one step closer to realization, although such a vaccine remains many years away.

So far, 15 candidate vaccines have undergone limited tests. The World Health Organization (WHO) is working with the governments of Brazil, Rwanda, Thailand, and Uganda to strengthen their scientific and medical infrastructure and so enhance their capacity to conduct large-scale vaccine trials. The US National Institute of Allergy and Infectious Diseases is doing similar work in eight developing countries.

There are already a number of ways of preventing infection with HIV, the human immunodeficiency virus, such as providing condoms, promoting safer sex, and early diagnosis and treatment of sexually transmitted diseases (STDs). "But these have been only partially successful, and a safe and effective vaccine would be an important tool," says Michael Merson, executive director of WHO's Global Programme on AIDS (GPA).

According to WHO, the ideal AIDS vaccine should protect against HIV in uninfected individuals; prevent disease progression in HIV-positive people; reduce the virus's transmissibility; and prevent perinatal, or mother-to-infant, transmission. But the testing required now to find such a vaccine poses a range of difficult problems.

Why the developing world?

"When we help scientists in Rwanda, Uganda, Thailand, and Brazil develop plans for vaccine evaluation, the first question is 'Why us?'," says Jose Esparza, head of vaccine development at GPA.

For one thing, Esparza says, the need for an AIDS vaccine is greatest in developing countries, many of whom are already under an intolerable economic burden because of the AIDS pandemic. These countries must be involved in large-scale trials, he argues, since a vaccine based on HIV strains commonly found in Europe and the US would be of limited use in developing countries. Vaccines need to be tested in communities and countries where there is a high rate of new HIV infections. Rates of 3-5 new infections per 100 people are considered high. By this standard, many developing countries already have extremely high rates.

Vaccines are also being tested in developing countries because it is cheaper for the pharmaceutical companies. The higher rates of new HIV infections in these countries mean that smaller sample sizes are needed—for a shorter period of time—to determine whether or not a vaccine prevents infection.

"Uganda will participate in vaccine trials basically because we are trying to find a vaccine or a cure for AIDS," says Manuel Pinto, director general of the Ugandan AIDS Commission, adding that the country has an estimated 1.5 million people infected with HIV. "We have a vested interest, yes. But we also recognize that AIDS is a global human problem and as members of the global community, we have a duty to participate."

Others have severe doubts about the probity of testing AIDS vaccines in developing countries. They say it will be another example of "safari" or "hit-and-run" research: Medical research conducted in poor countries by scientists and pharmaceutical companies from rich countries because it is cheaper and easier, and fewer questions are asked about safety and ethics; and where the financial and social profits rarely benefit the poor populations or countries that played host to the researchers.

Is there a 'magic bullet' for poverty and the structural oppression of women?

"As an African," says a Ugandan doctor who prefers not to be identified, "I've seen situations where people have been used in trials of drugs and vaccines who have certainly not benefited from the fruits of such research." The hepatitis B vaccine, for example, is still too expensive for use in many developing countries.

Leaving aside the most obvious benefit of a vaccine trial—the

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Richard Mack

development of a successful vaccine—there may be other gains for developing countries. "The development of laboratories, improved infrastructures, and better-trained scientists and doctors are all huge advantages for a developing country," says Senegalese AIDS expert Souleymane M'Boup. "Once the trials are over, these structures and this expertise will remain, and will be useful even beyond the field of AIDS research and treatment."

Ethical dilemmas

Has the emphasis placed on strengthening scientific and medical infrastructure in developing countries been at the expense of ensuring proper ethical review? Carel IJsselmuiden of the Medical University of Southern Africa, in South Africa, thinks so.

"Much less attention has been given to developing ethical review expertise in the developing world, while it can be easily argued that such capacity building should precede and equal the technical capacity building," says Dr. IJsselmuiden, who conducted a special study of the ethics of AIDS vaccine trials in Africa.

Scientists conducting vaccine trials have an ethical obligation to look after the health and well-being of participants. "AIDS is a condition which is, in theory, 100 per cent preventable," IJsselmuiden says. "The people you're going to try your vaccine on must be given information and condoms."

But here an ethical dilemma arises: If trial participants are successfully educated to protect themselves against HIV through behaviour change and condom use, how will scientists be able to tell if a vaccine protects against HIV infection? There is a clear tension here between the amount of health education given, and the need for trial participants to be exposed to HIV.

"We need to do everything possible to prevent infections, knowing that we will not prevent all of them," says GPA's Esparza. "And so we need to decide what is ethically appropriate, what is sufficient counselling." But who should make the decisions about

how much health education is "ethically appropriate"?

Then there is the question of informed consent.

The principle of informed consent means that anyone who participates in medical research is fully informed and understands the nature of the research and any possible risks or effects associated with it. Informed consent presumes that individuals participating in research are competent to make decisions about whether or not to participate, and that they have not been subjected to any form of coercion, undue influence, inducement, or intimidation.

David Heyman, a GPA doctor, is well aware that for many people in the developing world, "better health care, in itself, might be an inducement or coercion to participate in trials."

Obtaining informed consent presents a number of problems. Western models of disease and contagion may not be intelligible to other cultures. Many health educators already find it difficult to communicate the notion of cause and effect between "invisible" HIV infection and the "visible" onset of AIDS several years later. Explaining the complexities of the vaccine trial—a "randomized", "double-blinded", "placebo-controlled" affair—to someone who is unfamiliar with these concepts is a formidable challenge.

Helen Jackson, who runs an AIDS information network in Zimbabwe, has doubts about the rigour with which informed consent will be obtained. "The safeguards do sound good and proper, but in a field situation, with pressure to recruit a large number of people, I wonder how strictly the guidelines will be observed."

Before joining an AIDS vaccine trial, prospective volunteers will have to be tested to determine whether they already have HIV. Only HIV seronegative people are suitable to participate in trials of preventive AIDS vaccines. Volunteers for the trials will effectively have to give two sets of informed consent, one for an HIV test, the other to join the vaccine trial. In some places, Jackson says, "informed consent for an HIV test is often nominal. It's a really easily abused concept." If so, the principle of informed consent for AIDS vaccine trials might be abused equally as often.

When a volunteer is vaccinated with a candidate AIDS vaccine, he or she will almost certainly become vaccine-related seropositive, meaning that he or she will carry HIV antibodies as a result of vaccination. Although vaccine-related seropositivity may be differentiated from infection-related sero-positivity by sophisticated testing, such tests are generally unavailable in developing countries. A volunteer who is vaccine-related HIV seropositive may risk all the stigma normally experienced by people who are infected. This might mean becoming unacceptable as a sexual partner, as a husband, a mother, or a wife. It could mean travel and immigration restrictions, or discrimination in employment, housing, and education, and perhaps even limited access to health care.

Another consequence of participation in an AIDS vaccine trial might be that vaccination with a candidate AIDS vaccine which subsequently proves to be ineffective, may prevent another, effective AIDS vaccine from working.

Some argue that arrangements for compensation and care in the case of medical complications arising from an AIDS vaccine trial are vague and inadequate. "I think a major problem with any vaccine or drug trial relates to medical follow-up," says IJsselmuiden. "Many trials are not giving guarantees for medical care relating to complications."

And, programmers say, there is always the risk that the population at large will mistakenly believe that a successful vaccine has been found and abandon safer sex, undoing years of preventive education.

Who gains?

What happens if and when a successful AIDS vaccine is found? The pharmaceutical company that has its AIDS vaccine licensed for use stands to make vast profits. But who else will benefit?

The principle of distributive justice demands that the burdens and benefits of medical research be shared equitably. Developing countries that shoulder the risks and burdens of vaccine trials in their populations believe they have a right to share in the benefits of an effective AIDS vaccine. But it's unlikely that all—perhaps not even any—of the candidate vaccines will prove effective and be licensed for use. This makes distributive justice something of a lottery: will the country hosting the trials of a successful vaccine be the only one to benefit from the vaccine, even though many other countries have shared the burdens of trials?

And if an effective vaccine is developed, will it be available and affordable for poor countries? Both WHO and the US National Institute of Allergy and Infectious Diseases are committed to the concept of an affordable AIDS vaccine for developing countries. But neither organization has regulatory powers to compel pharmaceutical companies to sell an AIDS vaccine at a price developing countries can afford.

The precedents are not always encouraging. Look at the hepatitis B vaccine, says British AIDS expert Tony Pinching. "Here is a proven, safe vaccine which provides substantial protection. And yet, although the great bulk of hepatitis B occurs in the developing world, far too few people are vaccinated against it."

For now, there is no available AIDS vaccine. Nor is there likely to be a safe and effective vaccine for at least a decade. AIDS will continue to ravage developing countries until well into the next century. No vaccine, however effective, will stop the AIDS pandemic overnight, nor eradicate the reasons for its spread.

"The quest for a preventive vaccine," says IJsselmuiden, "has the attraction of a 'magic bullet'—that is, the expectation or hope that we will not have to deal with many of the reasons underlying the distribution and spread of AIDS and HIV, namely poverty, underdevelopment, and the structural oppression of women all over the world."

Women and AIDS

Since no known sexually transmitted disease confines itself to one sex, it has been known that women would become infected with the human immunodeficiency virus and suffer from AIDS. Yet AIDS has been treated, for the most part, as a male disease. Investigative journalist Gena Corea sets out to show how women in the United States have been discriminated against from the earliest days of the epidemic, in *The Invisible Epidemic: The Story of Women and AIDS*. Her detailed book is replete with examples:

- Deaths of young women from a variety of respiratory infectious diseases began increasing dramatically in 1981 in areas with heavy concentrations of AIDS. But the fatalities have never been counted as AIDS deaths.
- The primacy of foetal health—even the health of a nonexistent but imaginable foetus—has excluded women from clinical drug trials.
- AIDS Clinical Trials Groups (ACTGs), the system of co-operative medical institutions conducting federal clinical AIDS drug trials, were created in 1987 in the United States. Nineteen ACTGs assess various substances for efficacy and safety in treating children with AIDS. Until 1992, however, not one trial had been designed to evaluate treatments for AIDS and AIDS-related opportunistic infections—otherwise harmless infections that take advantage of the weakened immune system—in women.
- The Centre for Disease Control and Prevention (CDC) recognizes candidiasis as an AIDS symptom when it appears in the throat, as it does in many AIDS-infected men, but not when it appears in the vagina, as it does in many infected women.
- The CDC surveillance definition of AIDS does not contain a single woman-specific opportunistic infection. Health activists say this has led to an undercounting of infected women and an artificial deflation of the actual dimensions of the AIDS pandemic.
- Although research shows that a man is ten times more likely to transmit the virus to a woman than the other way around, women are stigmatized as vectors of AIDS to men. Women's own risk of contracting the disease has been given scant attention. While female sex workers have been vilified for transmitting the disease, the real scandal is that their own risk of contracting the virus has been ignored.

Worldwide, there are five major areas of neglect and deficiency regarding women in current AIDS prevention and care efforts: data collection; female controlled methods of prevention; information and education programmes for women (most such programmes are limited to sex workers and pregnant women); exclusion from clinical research; and neglect in as well as exclusion from policy-making.

Corea weaves stories of women's experiences, told in their own words, into the narrative of this heavily-documented book. These are stories not only of suffering, but of women's resistance to being marginalized. She concludes: "We need to join with others: looking at AIDS policy, treatment, and research and becoming a chorus of voices on our own behalf; confronting city, state, and federal governments; exposing the politics of scientific knowledge; working to scrap a medical care nonsystem that so demeans our lives it provides medical care as if it were just another widget to be marketed and sold; advocating a health service respectful of women and people of colour; voting out of office politicians who ignore our challenge to the male hogging of resources and our calls for an equitable distribution of state and federal funds; challenging the economic exploitation of women—limited career opportunities and low, unequal wages—that, by keeping women dependent on men for survival sets us up for sexual exploitation." Available in hardback, priced at US$23.00. Published by: HarperCollins, 10 East 53rd Street, New York, NY 10022-5299, USA.

Reproductive Tract Infections

Hundreds of millions of women suffer from reproductive tract infections (RTIs), most of which are sexually transmitted. Some, such as yeast infections, are due to an excess of organisms normally present in the vagina, while others result from poorly performed gynaecological, childbirth, or abortion services. *Reproductive Tract Infections: Global Impact and Priorities for Women's Reproductive Health* is a compilation of papers presented at a 1991 conference organized by the International Women's Health Coalition and the Rockefeller Foundation. The papers set out to assess the implications of RTIs for international health goals, including women's health, family planning, safe motherhood, child survival, and HIV control. They examine the impact of RTIs on the lives of women, and propose and assess the means and resources with which the infections can be prevented, controlled, and treated. Published by Plenum Press, New York and London, under its "Reproductive Biology" series. For more information, contact: International Women's Health Coalition, 24 East 21st Street, New York, NY 10010, USA. Telephone: (212) 979-8500. Fax: (212) 979-9009.

AIDS in the Community

Living with AIDS in the Community is an illustrated booklet published by

the World Health Organization's Global Programme on AIDS. It aims to provide practical information to encourage people with AIDS and HIV, the human immunodeficiency virus, their families, and their friends to "adopt positive attitudes in coming to terms with the disease and in learning how they can make the best of their lives," the publishers say.Based on a booklet produced in Uganda, it is available in English and French from: GPA Document Centre, World Health Organization, 1211 Geneva 27, Switzerland. Individual copies will be supplied free of charge to readers in developing countries.

AIDS in Tanzania

By 2010, some 5.8-17.4 per cent of Tanzania's population will have been infected with HIV, up from today's HIV prevalence of 1.4-5.3 per cent, according to *Tanzania AIDS Assessment and Planning Study*, published by the World Bank. Among the report's recommendations: "The proven effectiveness of condoms to prevent [sexually transmitted disease]/HIV transmission should be acknowledged, and their use should be actively promoted for disease prevention as well as for family planning." Also, "the increased demand for health care brought about by the AIDS epidemic should not be allowed to divert resources from preventive health measures, both those to prevent AIDS and those directed at the many other preventable conditions which present the greatest threat of illness and death to the vast majority of the population." For more information, contact: The World Bank, 1818 H Street, N.W., Washington, D.C. 20433, USA. Telephone: (202) 477-1234. Fax: (202) 477-6391.

HIV and Development

HIV and Development is a 16-page introduction to what is known about HIV. It sets out to explore HIV's impact on economic and social development as well as the difficulties developing countries face in managing the pandemic. Available at a cost of US$2.95 plus US$1.00 (shipping) from: The Panos Institute, 1717 Massachusetts Avenue, N.W., Suite 301, Washington, D.C. 20036, USA.

AIDS Costing

AIDS is no longer just a baffling disease of the immune system. It is a development issue that feeds off and contributes to poverty, according to a report from the Panos Institute. The pandemic's direct health costs, estimated at between US$2.6 billion and US$3.5 billion a year, are likely to rise as the death toll increases from some 100,000 a year now to a projected 400,000 a year by the end of the decade. Add to this costs such as loss of output from disability and premature death and by people who are not infected but who spend time caring for others; possible increases in wage costs as a result of labour shortages; damaged tourist industries; children withdrawn from schools to look after sick parents or because fees cannot be paid; key industries hit by sickness and death among skilled workers; and overburdened social structures. The result, as Michael Merson, director of the World Health Organization's Global Programme on AIDS puts it: A situation in which "all sectors of life are threatened," as is "the development process itself." According to the report, *The Hidden Cost of AIDS: The Challenge of HIV to Development*, studies show that early preventive measures could save not just lives but expense—a lesson it commends to countries with apparently low rates of infection, such as China and the republics of the former Soviet Union. The report also warns against concluding that AIDS will nullify population growth: Most scenarios depict no more than a slowing in the population growth rate as the epidemic spreads. But since AIDS primarily targets 20-24-year-olds, the ratio of working adults to young and elderly dependents is likely to shift for the worse. Priced at £9.95, *The Hidden Cost of AIDS* is available from: The Panos Institute, 9 White Lion Street, London N1 9PD, UK. Telephone: 071-278-1111. Fax: 071-278-0345. A limited number of free copies are available to developing country organizations.

Fellowships

The Population Research Laboratory at the University of Southern California's Department of Sociology is offering predoctoral traineeships in population studies funded by the William and Flora Hewett Foundation, the Fred H. Bixby Foundation, and the Hugo R. Santora Endowed Fellowship Fund in Memory of Jene F. Foote. The fellowships are available as of 1 May and 1 September 1994. Awards funded by the Hewlett Foundation and the Santora Fellowship are limited to students from developing countries. Trainees are enrolled in population studies programmes in social science departments or in the Schools of Gerontology and Public Administration. Letters of inquiry should be accompanied by vitae and three letters of recommendation, and should be addressed to: Maurice D. van Arsdol, Jr., Population Research Laboratory, 3716 South Hope Street, Room 385, Los Angeles, CA 90007-4377, USA. Telephone: (213) 743-2950. Fax: (213) 743-7408.

DICTIONARY

AIDS & HIV

AIDS (Acquired Immune Deficiency Syndrome) is a condition believed by the scientific mainstream to be caused by **HIV**, the human immunodeficiency virus. HIV attacks the body's immune system, which fights off infections. The immune system's breakdown can result in serious, often deadly infections and cancers. These are called opportunistic infections because they exploit the body's weakened defences.

HIV-positive people have developed antibodies to HIV. This does NOT mean they have AIDS or that they will definitely develop AIDS in the future. Some remain completely healthy for a long time; some never develop AIDS. Others develop some symptoms, but no major infections. And others develop full-blown AIDS from three to ten years after infection.

HIV-negative people have not developed HIV antibodies. This does not guarantee they are virus-free; antibodies can take from six weeks to a year to show up.

(Source: Gay Men's Health Crisis)

Contraception: Protection against infection?

Contraceptive method:	**Extent of protection against sexually transmitted diseases (STDs) and HIV:**
Condom	Best method for protection; condoms made from animal membrane are less effective, however.
Spermicides	May offer some protection against STDs; effect on HIV needs further study.
Diaphragm, Sponge, Cervical cap	Some protection against STDs when used with spermicides; effect on HIV needs further study.
IUD (intrauterine device)	No protection. In fact, risk of pelvic inflammatory disease (PID) is increased in women at risk of STDs.
Oral contraceptives	No protection against STDs/HIV, some against PID.
Injectables	No protection against STDs/HIV, some against PID.
Implants (eg: NORPLANT®)	No protection against STDs/HIV, some against PID.
Female sterilization	No protection against STDs/HIV, maybe some against PID.
Vasectomy	No protection.
Natural family planning (rhythm, withdrawal)	No protection.

Sources:

- Population Reference Bureau, "Controlling Sexually Transmitted Diseases," *Population Reports*, June 1993.
- World Health Organization, *Contraceptive Method Mix: Guidelines for Policy and Service Delivery*, as reported in: Program for Appropriate Technology in Health (PATH), "Contraceptive Method Mix: The Importance of Ensuring Client Choice," in *Outlook*, Vol. 10, No. 1, May 1992.

"Population and Our World"

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Noudjoud Ait Yakhaf,
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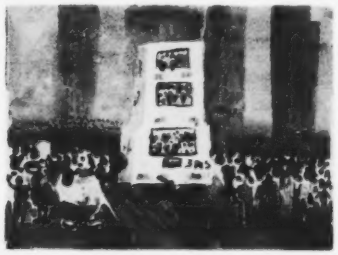

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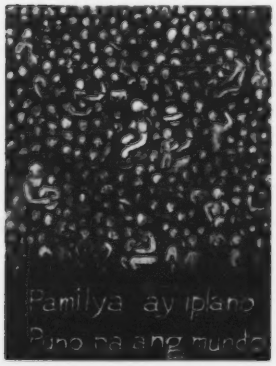

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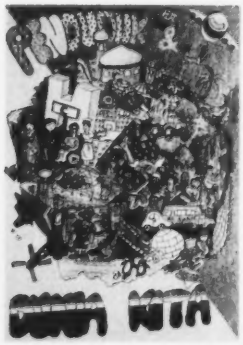

Sim Yen Chin, Malaysia,
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